a patient with ectopic pregnancy, eclampsia, or placenta previa. The second is the hazard of possible criticism of the attentions given the patient by the physician in charge. The suggestions given may be most helpful, but the probabilities of fanning into flame the local jealousies are too great. Moving pictures probably will supply this deficiency to a large degree.

Some years ago our State Society urged the county organizations to appoint committees on postgraduate work and outlined topics suitable for presentation. While many of the meetings so sponsored were of excellent grade, the real values oftentimes were obscured by the necessity of covering too many subjects in a short time. The usual procedure was to hold a "Postgraduate Day," and possibly six rather unrelated presentations of an hour each left the listeners paralyzed from so lengthy a session. By the time the last speaker had finished, the material presented in the first lecture was forgotten. For a balanced mental diet, too many meat courses were served, and too rapidly for adequate digestion.

Because we saw the error inherent to this indiscriminate grouping, and because we felt that a better interest in obstetrical matters would lead to better obstetrics, some half dozen of us in Los Angeles decided upon offering independently a series of talks, each of us selecting two subjects. This we began two years ago. Naturally our first efforts were somewhat inept. We had to learn by experience to condense theory interesting to select groups and to emphasize specific points in practice. In time, we may develop a definite service to our neighboring areas, provided, of course, that they can put up with us until we really are of value.

RECOMMENDATIONS

But this effort cannot measure up to the Iowa project. For one thing, we have practices to maintain, and must substitute speakers on occasion, according to the demands of our patients. For another, distances in California are great, and the outlying counties must not be forgotten. It would seem that a better coverage and by better lecturers should be possible. Specifically, I suggest that the California Medical Association authorize the payment of travel expenses of lecturers on obstetrics, at the various county centers. This would relieve the lecturer of expenses which are not properly his own, and would give every physician wherever situated a definite interest in the State Society. Next, the lecturers should be selected by the professors of obstetrics at California and Stanford in the North, assisted by the professors at Southern California and the Medical Evangelists in the South. Who better qualified to know which men to present a given subject in forceful fashion? I suggest further that such proposed lectures be arranged as a course of eight to twelve separate talks and presented as a unit. Not more than two papers should be given on any one date, separated, if possible, by the dinner hour. A session each week gives time to absorb and arrange mentally the pertinent facts given by the last speaker, and to meet the next with freshened interest. Probably the arrangement of topics could be added to the duties of the professor at our state school, provided that the next appointee possesses the driving force and organizing ability that has been the happy possession of the present incumbent. While a more unified service could be rendered were one lecturer to conduct an entire course, this is not feasible except where full-time teachers are available. None of us in practice could afford to maintain for long a schedule of one or two nights per week away from our usual haunts. A further practical objection to the one-man course is that there are few indeed who can speak entertainingly upon more than three or four subjects. Since our medical school departments are not on a full-time basis, the arrangement of a team of speakers becomes automatically the only solution available. Lastly, a small registration fee would aid in the meeting of expense accounts and insure continued interest.

IN CONCLUSION

This thought, then, I leave with you. Our annual meeting and our county sessions are not enough. Our reading, valuable as it is, lacks continuity. Detail men are more interested in the building of demand for products than in the dissemination of education. We must lift ourselves by our own bootstraps—and we have at hand bootstraps of quantity and quality.

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CUTANEOUS AND MUCOUS MEMBRANE CANCER*

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THERE always has been, and there probably always will be, great argument between dermatologists, surgeons and roentgenologists as to the "best treatment" of skin and mucous membrane cancers. It can be said without fear of contradiction that the first necessary element in this "best treatment" is skill in recognizing the clinical picture of these malignancies and, what is just as important, an equal skill in recognizing the clinical pictures of the various dermatological entities which may mimic them. There can be less certainty about the second necessary element in this "best treatment," that is, which type of therapy should be applied to any given cancer.

I have always had a strong personal preference for the destructive methods of therapy, such as electrosurgery, the actual cautery or excision, over radiation therapy. However, I have always felt that any physician who is especially interested in this field should have available to him, and should be expert in the use of, all of these modalities.

Because of the many wordy battles in which I have engaged relative to this subject, I decided a

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couple of years ago to review my cases in order to speak more accurately concerning my own results. Accordingly, in the fall of 1939, a study was begun of the cases treated in my practice and that of my partners, Doctors C. J. Lunsford and H. V. Allington. It did not include the large number of cases that have been seen and treated at the Alameda County Hospital and clinics because I felt that the results as seen in our private practice would be more representative of our efforts.

It should be admitted at the outset of this discussion that our statistics cannot compare in accuracy with those of institutions or groups who employ expert record clerks and statisticians for constant control of their records. Neither I nor my office secretaries are particularly skilled in this field. There are several other factors which make it difficult to attain statistical accuracy in a survey such as mine. Many of these patients, already in the older age group when treated, had died of old age or other causes before this study was begun. Others had moved in the intervening years and could not be located. But in spite of all of these difficulties I feel that my figures are a rough index of what has been accomplished in an ordinary private practice.

Up to date my partners and I have seen approximately 2,000 cases of skin and mucous membrane cancer. Of these, 1,502 were seen up to 1939 and are included in this study. The sexes were about equally represented in the 1,502 cases. No particular study was made of the age distribution, but it can be stated that most of the cases occurred in the group past middle life, as would be expected. The great majority of lesions were found on the face and neck, 76 per cent. Seven per cent were located on the lower lip.

As many of the patients were seen in consultation for other physicians, and as some did not accept our advice as to treatment, the total number of those treated and subsequently included in this study is 1,281.

BIOPSIES

Biopsy specimens were taken from 262 of the 1,281 treated cases, roughly 20 per cent. Our policy in regard to biopsies is to omit them when the lesion is typically epitheliomatous in appearance. Most of the patients in this series were checked by all three members of our group. When there was any disagreement or when the lesion was atypical, a biopsy was done. I believe this policy is a safe, practical one in the hands of physicians experienced in this kind of work. Less scarring results in those cases in which a biopsy is not needed. I recently personally interviewed a large number of the leading dermatologists of the United States and found that the great majority of them followed a biopsy policy similar to ours. It should be emphasized that when there is any doubt as to the clinical diagnosis a biopsy must be done.

About half of the biopsies from lesions of the glabrous skin were squamous cell epitheliomas and half were basal cell epitheliomas. A few belonged to the "mixed" group of basal-squamous type, a type of microscopic picture which exists, I believe, more often than is generally stated. As would be expected, nearly all (94 per cent) of the epitheliomas of the lower lip were of the squamous cell variety with only a few of the basal cell variety. Of those seen on the upper lip, a higher percentage (33 per cent) were basal cell in type, probably because they arose from the skin at the mucocutaneous junction and spread onto the lip. All biopsies from lesions from mucous membranes other than the lips showed a squamous cell structure. Of the unusual malignancies, our series included one each of lymphosarcoma, sarcoma, pagetoid epithelioma, two examples of erythroplasia of Queyrat, three of lymphoblastoma and five melanomas.

METHODS OF TREATMENT

An analysis of the methods of treatment employed discloses our preference for destruction by electrosurgery which was used in 71 per cent of our cases. Sixteen per cent were treated by destruction followed by radiation, 7 per cent by radium alone, and 6 per cent by x-ray alone. When we treat by means of radiation, we use fairly heavy doses; for example, in treating epitheliomas of the skin, we give from 3,000 to 5,000 roentgen units of unfiltered radiation usually in a single treatment.

CANCER OF THE SKIN

Of 1,131 treated cutaneous epitheliomas, 91 were completely lost track of and are not included in our results. Of the balance, 98.7 per cent were classified as "cured" and 1.3 per cent as known failures. A breakdown of the "cured" cases shows that 47 per cent of them were well when last seen less than two years after treatment, 31 per cent between two and five years after treatment, and 22 per cent were well five years or more after treatment.

CANCER OF THE LOWER LIP

One hundred and ten men, and three women had cancer of the lower lip without glandular involvement. One hundred and two were treated, but ten were lost track of and were not included in this study. Of the ninety-two cases studied three are known to be failures and eighty-nine are "cured"—forty-two for one to two years, thirty-two for two to five years, and fourteen over five years.

When treating lip cancer we rely mainly upon destruction by electrodesiccation or electrocoagulation. Forty-six of our patients were treated by these methods. Earlier in our experience we followed destruction by heavy doses of x-ray (47 patients in this series), but in recent years I have been omitting the x-ray, as I am certain that the percentage of cures is just as high without it and that the cosmetic results are far better when it has not been used. Three of our patients were treated by x-ray alone, and six by radium alone. None of these lip cases had glandular involvement, and in none of them was filtered x-ray given to the gland-bearing area of the neck.

CANCER OF THE UPPER LIP

An interesting finding in the series of upper lip cases is the high incidence (72 per cent) in women. Thirty-one cases were treated and all were finally classified as "cured"—eleven less than two years, fourteen between two and five years, and six over five years. Eighteen were treated by destruction alone, eight by destruction plus radiation, four by radium and one by x-ray.

All of our cancers of the lip, either upper or lower, are treated in the office, hospitalization being unnecessary. If the lesion is of the usual size, it is blocked off by procain. In a few instances of extensive involvement of the lower lip I have used double mandibular nerve block.

CANCER OF THE ORAL CAVITY

Forty-seven patients were seen with cancer of the tongue or oral cavity. Thirty-five of them were treated by us. Our main weapon in these cases was extensive electrocoagulation, but we often supplemented it with implants of radium seeds or deep roentgen therapy. Of twenty-nine patients who presented no glandular involvement at the time of operation, three were lost track of, seven are known to have died of the disease, and nineteen are tentatively classified as "cured." Of these nineteen, six have been well for less than two years, eight from two to five years, and five have been well over five years. Six patients were treated by us with advanced cancer of the oral cavity showing extension to the glands of the neck. All of them died in spite of treatment, which generally consisted of destruction, plus radium implants, plus deep roentgen therapy. As I look back upon this group I sometimes wonder, but generally doubt, whether or not extensive neck dissections would have improved our results.

OUR OWN RECURRENCES

A study of our own thirty-seven recurrences has been of particular interest to me. Recurrences were seen in 18 per cent of the patients whom we treated by radiation (10 per cent radium and 8 per cent x-ray), in 2 per cent of those whom we treated by destruction, and in 2 per cent of those treated by destruction plus radiation. This would indicate to me that in our hands the destructive forms of treatment are far less apt to be followed by recurrences than when radiation is used. It also shows that the percentage of recurrences is not lowered by using radiation after thorough destruction. Five of our thirty-seven patients with recurrences refused further treatment, one was lost track of, two died from the disease, two were cured by other physicians, two were cured by our x-ray and twenty-five were cured by us by destruction.

RECURRENCES AFTER TREATMENT BY OTHERS

Thirty-four patients came to us because of cancers which had recurred following treatment by other physicians. Nineteen of them had been originally treated with radium, eight by x-ray, one by carbon dioxid snow, one by curettage, one by electrodesiccation and three by methods unknown. Twenty-nine of these recurrences were treated by us—twenty-one by destruction, three by radium, one by x-ray and four by destruction plus radiation. Two of these patients died, one was lost track of and twenty-six are considered cured.

The death rate among 1,281 patients treated by us was 2 per cent. As would be expected, the highest percentage of the deaths occurred in our mouth and tongue cases.

SCARRING

When I originally undertook this study I had hoped to be able to find out how satisfactory or unsatisfactory were the scars which resulted from destructive forms of therapy, and to be able to compare them with scars resulting from radiation therapy. It has always been my impression that although the scarring immediately following destructive forms of therapy is worse than that following radiation therapy, in the long run the scars following destruction are less objectionable. Scars from destruction therapy improve with time, while those from heavy radiation therapy may become worse, may become atrophic, telangiectatic and may degenerate into radiation malignancies. However, my figures are too inconclusive to settle this question. Too often our case records failed to say much about the cosmetic character of the scar, and too often in the questionnaires would the patient say the scar was satisfactory in view of the seriousness of the condition. Parenthetically, it may be of some interest to note that after the seriousness of skin cancer has been explained to these patients of the upper age group, they are perfectly willing to accept the danger of scarring.

Of 367 case histories which accurately described the scar at the end of treatment, twenty of the scars seemed conspicuous to me. But of the same series, only ten (3 per cent) of 289 patients who answered the questionnaire, said that the scars were objectionable.

COMMENT

The results as given above are those obtained in consecutive unselected cases of skin and mucous membrane cancer seen in our private practice of dermatology. Although destruction by means of electrodesiccation, electrocoagulation or the actual cautery was the favored method of treatment, heavy doses of unfiltered x-ray or appropriate doses of radium were available and were given when we considered them indicated.

The results that we obtained are, I believe, roughly the same as those of dermatologists throughout the country.

I feel that the diagnosis and treatment of these purely ectodermal tumors lie particularly in the field of dermatology. Not only is the dermatologist best equipped to deal with their differential diagnosis, but also he is thoroughly trained to use, and has available, all of the modalities necessary in their treatment.

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